A qualitative study of the cultural changes in primary care organisations needed to implement clinical governance

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SUMMARY

Background: *It is commonly claimed that changing the culture of health organisations is a fundamental prerequisite for improving the National Health Service (NHS). Little is currently known about the nature or importance of culture and cultural change in primary care groups and trusts (PCG/Ts) or their constituent general practices.*

Aims: *To investigate the importance of culture and cultural change for the implementation of clinical governance in general practice by PCG/Ts, to identify perceived desirable and undesirable cultural attributes of general practice, and to describe potential facilitators and barriers to changing culture.*

Design: *Qualitative case studies using data derived from semi-structured interviews and review of documentary evidence.*

Setting: *Fifty senior non-clinical and clinical managers from 12 purposely sampled PCGs or trusts in England.*

Results: *Senior primary care managers regard culture and cultural change as fundamental aspects of clinical governance. The most important desirable cultural traits were the value placed on a commitment to public accountability by the practices, their willingness to work together and learn from each other, and the ability to be self-critical and learn from mistakes. The main barriers to cultural change were the high level of autonomy of practices and the perceived pressure to deliver rapid measurable changes in general practice.*

Conclusions: *The culture of general practice is perceived to be an important component of health system reform and quality improvement. This study develops our understanding of a changing organisational culture in primary care; however, further work is required to determine whether culture is a useful practical lever for initiating or managing improvement.*

Keywords: *clinical governance; organisational culture; quality; primary care groups; trusts.*

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Introduction

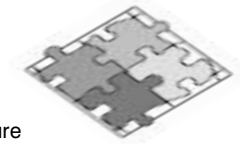
THE term 'clinical governance' describes one of a wide range of policies to reform the National Health Service (NHS) in the United Kingdom (UK).[1,2] The key components of clinical governance are accountability for continuous improvement, safe-guarding standards, and the creation of an environment conducive to providing high quality care.[3] Clinical governance has been described as an 'organisational innovation'[4] and government documents purport that a change in the culture within NHS organisations is a fundamental prerequisite for its successful implementation in the NHS (Box 1). Investigations into recent high profile disasters in the NHS, such as the enquiry into paediatric cardiac surgery in Bristol, have focused on underlying cultural problems within the medical profession and the NHS.[5]

Despite this, the meaning of the word 'culture' is unclear — whether it is a convenient metaphor or a description of specific processes or desirable traits.[6] Some appear to regard culture as something tangible, perhaps measurable and even manageable.[7] Others see culture as an intrinsic property of an organisation which cannot be separated from its existence.[8] Despite this diversity of views, there is agreement that culture represents the shared beliefs and values within an organisation.[9,10] The supposition is that these might in turn influence, or at least have the potential to influence, the norms, attitudes, and behaviours of the members of that organisation.[6]

Seen in these terms, the implementation of clinical governance presents a significant cultural challenge to primary care groups and trusts (PCG/Ts). These new organisations are responsible for implementing clinical governance in general practice. Practices are historically autonomous in managerial terms and GPs are traditionally independently minded. They possess a wide range of norms and values, many of which are desirable but some of which may not be compatible with the espoused values of the reformed NHS.[1]

This study represents one part of a wider investigation of the implementation of clinical governance in general practice. The purpose of the paper is to describe the importance placed on culture and cultural change by senior managers and clinicians in primary care. In addition, we identify perceived desirable and undesirable cultural attributes of general practice, and potential facilitators and barriers to cultural change.

HOW THIS FITS IN



What do we know?

Government documents and policy experts state that a change in the culture of health organisations is a fundamental part of the NHS reforms, but to date there has been little interest in the importance of organisational culture within general practice.

What does this paper add?

This study suggests that senior primary care managers responsible for implementing clinical governance place a high priority on the need to change the culture of general practice to one that is more focused on accountability, collaboration between practices, and reflective learning. There are significant historical, structural, political, and professional barriers to facilitating or managing this change.

Method

Sampling and data collection

Between August and December 2000, semi-structured interviews were conducted with the senior managers of a sample of 12 PCG/Ts in England. The organisations were selected using a purposive sampling frame[11] to represent a range of characteristics, including size, rurality, and group or trust status (Table 1). In total 50 senior managers were interviewed from the 12 organisations, including all of the chief executives (12), lay board members (12), clinical governance leads (12 GPs and two nurse co-leads) and mental health leads (9). In addition we interviewed three senior managers (two board chairs and one executive committee lead) who were identified as key informants by the other interviewees.

The interviews were conducted at each of the organisation's headquarters by one of six experienced qualitative interviewers (SC, SH, MM, AR, RS, SP). The interviewers came from a range of disciplinary backgrounds and were responsible for interviewing all the selected managers in one or more of the sites. The content of the interviews was standardised using an outline schedule that had been piloted in three organisations prior to the main study (Box 2). The schedule was used flexibly to allow participants to contribute according to their roles, responsibilities, and interests. The word 'culture' was not introduced explicitly by the interviewer to avoid 'leading' the participants' responses.[12] The interviews lasted between 30 and 90 minutes and all were audiotaped. In addition, we reviewed relevant documentation, including annual reports, clinical governance reports, and communications to practices relating to clinical governance. Finally, observations of the ways in which the senior managers appeared to relate to each other and to the organisation during the site visit were recorded as field notes. Anonymity of individuals and organisations was assured.

Data analysis and interpretation

A thematic analysis of the data was conducted,[13,14] identifying passages of text relating to a theme or idea and then grouping them into conceptual categories. The themes were further developed by a process of iterative review of the interview transcripts, the documents, and the field notes and emerging ideas were shared and explored in regular meetings of the project team. For the purpose of this paper, explicit and implicit references to culture, shared values, norms, and beliefs, were searched for. In addition, evidence of cultural diversity, cultural change, and desired cultural destinations was sought. The process of sharing the data between researchers helped to improve the trustworthiness of the analysis and interpretation of the data. In addition, the findings within and between different data sources were triangulated and a sample of the draft reports was sent back to each participant for responder validation.[13]

'*Achieving meaningful and sustained quality improvements in the NHS requires a fundamental shift in* ***culture****'.*

'Clinical governance needs to be underpinned by a ***culture*** *that values lifelong learning'.*

Clinical governance will bring about 'a ***culture*** *in which excellence can flourish'.*

Box 1. The link between culture and clinical governance in the White Paper, A first class service: quality in the new NHS.[1]

Table 1. Characteristics of the 12 study sites.

Characteristic	Number of PCG/Ts
Geographical characteristics	
Predominantly rural	3
Predominantly urban	6
Predominantly inner-city	3
Group or trust status at time of study	
Group	6
Trust	6
Size of PCG/T (number of practices)	
Small (7–15 practices)	4
Medium (16–30 practices)	5
Large (31 or more practices)	3

- What do you understand by the term 'clinical governance'?
- What are your clinical governance priorities? How did you choose them? How are you implementing them?
- What organisational factors have influenced the implementation of clinical governance?
- Are/how are users views fed into the clinical governance agenda?
- What do you believe to be your successes with respect to clinical governance?
- What were the barriers to implementing clinical governance?
- How do you see clinical governance developing in the future?

Box 2. Summary of key questions in interview schedule (modified for different groups of interviewees).

Results

Importance of culture

The concept of the values, norms, and beliefs of members of the organisations and the extent to which these are shared emerged strongly and spontaneously from the interviews. The term 'culture' was used by over three-quarters of the interviewees and on 108 occasions in the 49 interviews.

Some participants used other terms; one referred to a 'mindset for the organisation' (chief executive, site E) and another stated 'we have, as a PCG and embryo PCT, spent a lot of time on values' (chief executive, site D). Cultural change was seen as a fundamental prerequisite for the successful implementation of clinical governance, which was perceived as 'an organisational, cultural, and systems issue' (chief executive, site D). A clinical governance lead reflected that there was a 'clear understanding that there needs perhaps to be a cultural shift from the past' (GP clinical governance lead, site D).

Despite the enthusiasm for the concept, culture was viewed in a non-specific way by most participants, one commenting that perceived resistance to change was 'a sort of culture thing' (lay member, site K). No-one suggested a clear meaning for the word. Most references were to the culture of GPs and it was clear that this was the dominant culture of the emerging primary care organisations in participants' minds.

Most of the responders expressed the need to balance specific clinical governance tasks, such as implementing the National Service Frameworks, with the need to create an atmosphere conducive to change. The former was described in terms of the 'rigid number-crunching mechanistic aspects of clinical governance', the latter was described as the 'slightly more nebulous cultural aspects' (GP clinical governance lead, site D). Some clinical governance leads saw their main role as facilitators for changing attitudes and values, suggesting that the accomplishment of specific tasks was perceived primarily as a vehicle for cultural change.

Cultural attributes of general practice

The data were analysed for references to perceived desirable cultural traits of general practice (Table 2). Senior managers were able to identify those characteristics that they thought would facilitate or inhibit the implementation of clinical governance. The need for greater accountability was regarded as one of the most important of these by both professionals and lay members: 'at the end of the day you've got to demonstrate what you've done; we're not in the ministry of nice feelings … we need to *see* quality and excellence as a result' (lay member, site E).

Cultural changes

Most participants felt that there had been a noticeable change in the culture of general practice in recent years. However, this was not universal and one clinical governance lead described 'levels of engagement' with change, from antagonism to apathy to ambivalence to support. She felt that the majority of practices were now ambivalent but more and more were being supportive of the concept of clinical governance.

The most significant cultural change noted by the participants was a greater willingness of practices to work together and learn from each other. This was felt to be primarily the result of out-of-hours co-operatives but clinical governance had tapped into the resulting goodwill. Closer co-operation was manifest by sharing information (usually in anonymised format but on a named basis in one organisation) and by benchmarking. Over half of the PCG/Ts in the study had allocated specific resources to fund protected time for clinicians from different practices to meet together.

The senior managers spoke about their attempts to create a conducive environment for cultural change but none suggested that they were able to actively control, manage or change culture. Nevertheless, they were able to identify factors that might facilitate the underlying trends. The most important of these was the need to build steadily on success and not to drive change too rapidly. Most responders felt that they had to resist external pressures to be able to manage the pace of change, as one commented: 'the health authority have wanted things done far too quickly' (GP clinical governance lead, site B). This reflected an apparent sensitivity to the many demands being made on GPs and the need to maintain goodwill: 'one volunteer is worth ten pressed men' (GP clinical governance lead, site C).

The need for practices to own any changes was also perceived to be important and several of the organisations stated that they attempted to align new initiatives to the personal and professional aspirations of the GPs: 'what we try to do is re-interpret things so it makes sense from where people are, so it seems to be supporting them to do things that they would want to do anyway' (chief executive, site F).

Barriers to change

The participants identified three principal barriers to changing the culture of general practice. First and foremost, the

Table 2. Perceived cultural attributes of general practice.

Attribute	Characteristic
Accountability	Willingness to demonstrate good quality practice using hard and soft evidence, including publication of comparative data relating to quality of care
Learning from other practices	Willingness to look outside own practice, to learn from others, sharing experiences and information
User involvement	Focus on partnership with patients, encouraging greater user participation, greater sensitivity to user needs
Orientation to scientific evidence	Greater use scientific evidence to guide clinical practice
Multi-professional team work	Willingness of GPs to work in partnership with other disciplines
Reflection	Ability to be self-critical and learn constructively from mistakes
Thinking across interfaces	Greater integration of activities and across traditional boundaries, e.g. health and social care, primary and secondary care

long history of independence and autonomy of GPs was perceived to be incompatible with the fundamental principle of collective responsibility underlying clinical governance: 'you can't tell them what to do … [you] can only put pressure on them in a very diplomatic way to get the practice involved' (mental health lead, site G). This independence was thought to result in isolation for some practices and to be the reason for the great heterogeneity of general practice: 'there is a vast variety of belief systems among GPs' (executive committee lead, site D); 'every single practice has its own kind of culture, way of working, unspoken values' (nurse clinical governance lead, site E). One chief executive commented that the independent contractor status of GPs would always place a limit on the extent to which the potential of clinical governance would be realised. Others complained that they had no authority over the resistant practitioners who 'stick their heads in the sand and hope it all goes away' (chief executive, site B).

The second barrier related to the political environment within which the health service was operating. All interviewees referred to the pressure to deliver on specific initiatives and one felt that: 'we'll get change only if people are given time to reflect' (chief executive, site D). Several responders spoke about the need to protect practices as much as possible from central demands. One clinical governance lead described himself as a 'buffer' and another felt that his job was to 'protect GPs from the sillier bits of government policy' (GP clinical governance lead, site F). Several interviewees spoke about the difficulties of achieving a balance between the need to police minimum standards and the need to adopt a developmental approach to quality improvement. There was a feeling that 'people see the wider government agenda as much more about policing' (GP clinical governance lead, site E).

The third barrier to changing culture was a perceived lack of the necessary skills among many of the managers in PCG/Ts and among people working in primary care. For example, while greater user involvement was seen as an important and desirable cultural attribute, at least in principle, few knew how to make it a reality. The end result is that there was much rhetoric but little progress in terms of giving users a louder voice.

Discussion

Senior managers of the primary care groups and trusts in this study concur with the policy rhetoric that cultural change in general practice is a fundamental part of the implementation of clinical governance. Despite acknowledged problems with defining culture,[15] this study suggests that participants engage with the concept in relation to efforts to implement clinical governance. Implicitly at least, they appear to regard culture in popular terms as the collective ways in which the people working in general practice think about and do things within their practices and within the primary care organisations. They are able to identify traits that they think will facilitate cultural change and ones that will inhibit or delay it. The most important of these are the value placed on public accountability of practices and the desire of practices to work more closely together. Primary care managers saw their primary role as being facilitators of an exchange of ideas between practices and as buffers between the demands of politicians and senior NHS managers and the capability of those providing the service to deliver on these demands. They operated on the basis that once practices start to talk to each other, change would then occur. There was a strong perception that the culture of general practice was changing and that this change could be facilitated but not actively managed. The main barriers to changing culture were seen as the level of autonomy and independence of the practices and perceived political pressures to deliver rapidly on specific tasks. In particular, cultural change was not seen as something that could be delivered within a short time scale.

The strengths and limitations of this study

There are different approaches to examining culture within organisations. Some favour a qualitative approach using participant observation,[26] interviews[19] or unstructured questionnaires.[27] Others prefer a quantitative approach and there are a range of tools which purport to provide a numerical measure of culture.[7,28,29] Some authorities suggest that a combination of these approaches is most useful.[9,30,31] Since the purpose of this study was to explore the importance placed on culture and desirable dimensions of culture, we decided to adopt a qualitative approach.

The study has a number of limitations. First, culture, like any social concept, is difficult to study empirically. The culture of a PCG/T is a complex phenomenon reflecting different 'sub-cultures', including that of individual health professions, teams, and practices. The medical culture of GPs was considered to be a strong determinant of PCG/T culture by the participants of this study and this finding has implications for facilitating cultural change. The culture of a PCG/T also reflects the 'super-cultures' of the NHS, the political system, and national traits. The impact of these 'levels of culture' on our understanding of health organisations is unclear. Whatever method of investigation is used, it is easier to identify the superficial manifestations of culture, such as attitudes and artefacts, than it is to study the more deeply-held underlying values and assumptions.[6,10]

Secondly, if culture represents the shared values of the people who work in an organisation, then the views of senior managers (albeit those with a clinical as well as a non-clinical background) will necessarily result in an incomplete picture. In future studies it is intended that the relationship between the perceived values of senior management and those of practice-based professionals should be evaluated: any differences may help to shed further light on the barriers to facilitating cultural change. However, since the leaders of an organisation are in a dominant position of responsibility and influence, and since leadership is regarded by many as a key component of culture,[7] leaders represent an important and valid starting point for any investigation of culture. In addition, there is a risk that, during the interviews, senior managers may have regurgitated policy statements rather than reflecting the real difficulties of service management. The researchers were sensitive to this issue throughout the process of data collection and analysis.

How this study contributes to existing literature

To our knowledge this is the first study to examine the emerging culture of clinical governance in new primary care organisations and its relationship to the established culture of individual general practices. Others have examined cultural issues in health care but they have tended to focus on professional subcultures,[16-18] or on the culture of hospitals.[19-22] There has been some work on the ways in which members of the primary health care team interact, the so-called 'team climate',[23,24] but this is only one component of organisational culture (personal communication, C Borrill, 2000). This study therefore provides a new insight into what is regarded as an important component of improving quality.[25]

Implications for future research, policy, and practice

Despite the valuable insights gained, this study leaves some questions unanswered. There is at present little evidence to suggest which, if any, cultural attributes can lead to improved quality of care, or indeed that culture has any impact on performance.[7,21] Even if this relationship was to be proved, we still do not know whether or how culture can be actively managed. Nor do we know how important a multi-agency approach might be to changing culture, incorporating organisations into the process other than the PCG/Ts and practices that form the focus of this study. We need to know the answer to some of these questions if the intuitively appealing concept of organisational culture is to bear fruit. Until we have more evidence it is reasonable to regard culture in general practice as an interesting and potentially important component of clinical governance but not yet as a lever for change.

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